Upper Bucks ORTHOPAEDICS

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Request for Completion of Disability Forms

Patient Name: _____ Patient Date of Birth: _____

1. **The time frames and charges for completion of Disability forms are as follows:**
   A) Non-expedited completion of forms: 10 business days- $15.00
   B) Expedited completion of forms: 5 business days- $25.00
2. **Please make sure that any forms provided to our physicians are fully completed and signed.**
   A) Any forms received that are not completed cannot be processed and the above time frames will not apply.
3. **Please list your occupation and a complete description of your job requirements:** (i.e. stands 8 hours, lift overhead 20lbs, kneeling, bending, etc). This will assist our physicians to identify what you will be able to appropriately and safely perform at your place of employment.
   Occupation: _____
   Job Requirements: _____
   _____

Date completed information was dropped off: _____
Disability Dates: _____
Return to work date: _____

When form is completed ( ) Call me to pick up – (Tele #:) _____
( ) Fax to (Fax #:) _____
( ) Mail to: _____
_____
_____

I give my consent to have Upper Bucks Orthopaedics release my medical information to: (Please provide the name of the company that will have permission to review your medical information in regards to your disability forms)

Name of Company: _____

_____ _____
Signature Date

Once all of the above information is completed on this form, our staff will proceed in completing the Disability forms in the time frame listed above.